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East Berlin PSYCHIATRIE, NEUROLOGIE UND MEDIZINISCHE PSYCHOLOGIE in German
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[Article by Michael Kreyssig, MD, Karl Marx University Psychiatric Clinic, Leipzig (Prof K. Weise, MD, director): "Psychological and Ethical Problems in Rehabilitating the Mentally Ill"]

[Text] Summary. In institutional psychiatry there is a discrepancy between the somato-therapeutic and the rehabilitative development level. In addition to objective factors, it is believed that the causes of this reside in the unsatisfactory development of medium-level medical personnel. It is especially the behavior and the attitudes toward the patient that reveal considerable remnants of authoritarian-hierarchical structures in psychiatry. There is a definite decline here as we go from clinics oriented toward social psychiatry to bezirk or specialized hospitals. Rehabilitation starts with the patient's personality. This is why the use of psychotherapeutic principles is a necessary requirement for the rehabilitation of psychic patients. On the subjective side of the therapeutic-rehabilitative process, it is necessary to give the patients an opportunity for developing from the submissive object of medical activity to the active (emancipated) and acting subject.

The therapeutic efforts of psychiatry should generally be permeated by the concern for rehabilitation, regardless of whether this involves the outpatient or inpatient sector. This would be completely in agreement with the basic purpose of rehabilitation which, in 1967, during the Ninth Conference of the Ministers of Health of the Socialist Countries in Prague, was stated in the following terms: "Rehabilitation in socialist society is a system of government, social-economic, medical, occupational, psychological,

and other measures aimed, first of all, at the prevention of the development of pathological processes which lead to a temporary or permanent loss of the ability to work and, second, at the effective and early return of the patient and disabled individual to society as well as to socially useful work" (quoted in Kabanov, 1976). It furthermore states that, as a result of rehabilitation, it is necessary to create an active relationship between the patient and the disturbance of his health and a positive attitude toward life, family, and society. Prevention and return to society are given equal standing.

Gastager introduced the terms late rehabilitation and early rehabilitation into psychiatry (1968). Volovik (1976) considers the early rehabilitation of schizophrenia--by which he means, among other things, the inhibition of progression, the promotion of preserved compensation mechanisms, and the defusing of disturbing factors in the social environment--to be just about identical to the prevention of schizophrenia. The elimination of the hospitalization syndrome, with its failure to adjust to unnatural living conditions, he places under the heading of late rehabilitation. The great significance of early rehabilition, which should start already on the level of outpatient treatment, emerges from a study on the "Institution Syndrome" (Freudenberg, 1962), according to which the chances of inpatients being released are in an inverse ratio to the duration of hospital admission. Outpatient psychiatric care, within the environment of the community, on an everyday basis, is assuming increasing significance as compared to inpatient treatment (which however it can never fully replace) provided it meets the requirements of the real social situation; this kind of community-based outpatient psychiatric care is best in keeping with the rehabilitation objective if it leaves the patient within society as a result of which social alienation is extensively avoided and because of which the expenditure and effort of returning the individual to society after hospitalization are spared both the patient and the institution.

In terms of returning the psychiatric patient who has received inpatient treatment, rehabilitation is identical to resocialization (Kabanov, 1976) because all inpatient treatment to a great extent further impairs the social relationships which were already disturbed anyway prior to the onset of the illness.

In the context of this contribution, we cannot consider the full complexity of the rehabilitation of psychiatric patients. After the very general remarks, which are in the nature of an introduction, we want to take up some ethical and psychological problems.

Considering the current development level of psychiatry, in which numerous somatic treatment methods are being used successfully, it seems that there is a wide gap between what has been achieved in somatotherapeutic respects and that which is possible in rehabilitative terms. This is supported by observations according to which even fully restored former psychotic patients, who were treated overwhelmingly by somatic methods, after discharge

from inpatient treatment are considerably impaired in terms of their ability to readapt in the normal social environment. The reasons for this are to be found, among other things, in the inadequate preparation of the patient for return to real life or in the abrupt separation from the hospital with its protective atmosphere. The patient often has not yet sufficiently broken away from his patient status; he feels insecure with regard to his social activities and relationships and assumes a rather self-protective attitude due to the seriousness of the illness. In most cases he still lacks essential characteristics of a healthy and fully accepted, equal member of society. On the other hand, his discharge meant that he left the institutionalized barrier of abnormality behind (see Baeyer, 1951) but the deal barrier still stands between him and the environment. On the "outside" he must regain his earlier values which were reduced due to his psychic illness; he must balance out the loss of position in the family and on the job and he must cope with prejudices that work against the psychiatric patient. The discharged patient cannot meet these requirements without corresponding preparation and supportive measures and he is in extreme danger of suffering a relapse. If that is the case, then essential reasons must be found in the failure of the rehabilitation efforts and to a lesser degree in the postulated procedural course of the illness.

The causes of insufficient rehabilitation among other things are to be found in the antiquated, one-sided orientation toward natural science and the somatic aspects and the mistaken concept of rehabilitation which is based on that and which is held in some places but often also the limited possibilities of the institution, such as inadequate personnel staffing, excessively large area to be serviced, insufficent number of beds, and geographic location far from population centers. These circumstances limit reintegration and lead to the neglect of the actual point of departure of psychiatric rehabilitation, that is, the personality of the patient, return to the family and resumption of occupational activity which in most cases boils down to merely getting the released patient a job.

The basis for rehabilitation in our specialized field is the exact knowledge of the patient's personality with its attitudes and expectations and with the patient's social relationships before and during the illness.

In the case of inpatients,we can often observe a withdrawal to the role of the sick person. That frees the patient from his other normal role obligations (family, job); he feels a co-responsibility for his responsibility and feels obligated to follow the doctor's treatment instructions (Parsons, 1958)[1]. He thus assumes a passive, submissive attitude and suffers a loss of ability to master real relationships between the individual and the environment. It is equally significant that, due to the illness and his hospital stay, his position in the most varied social groups and his social prestige are undermined, provided of course this did not already happen before he became sick.

Without a thorough analysis of the personality in the premorbid and timely social context, we do not have certain important prerequisites for therapy

and rehabilitation. The gap which still exists here must be closed through "basic work" along psycho- and socio-diagnostic lines. By that we mean, at the Leipzig Clinic, the comprehensive application of multidimensional diagnosis (Weise, 1971) based on a far-reaching patient history, if necessary, and a specifically target-oriented utilization of the diagnostic inventory of psychology. All those involved in the rehabilitation process must be drawn into the constant analysis of psychosocial factors in keeping with their opportunities and their job characteristics (for example, attendants, social workers, work therapists, etc.). The information obtained in this process constitutes the foundation for the therapeutic-rehabilitative "basic behavior" (Mann, 1976)--which remains to be discussed in greater detail below--in the concrete situation involving the encounter with the patient.

There is no doubt today that great therapeutic or also pathogenic significance must be assigned to the attitudes and behavior of personnel toward the patients. Personnel considerably influences the patient personality (Greenblatt et al., 1955; Weisse, H. and Petermann, 1976). The optimum structure of the psychiatric ward for the reduction of pathogenically significant attitudes on the part of the members of the therapeutic team and the patients in our opinion is the therapeutic community (Schirmer et al., 1974). It best accommodates the therapeutic-rehabilitative objective. In it, "the patient no longer plays the role of a passively receiving member depending on the institution; instead, he is built into the treatment plan as active participant and partner" (Veltin, 1965). This represents a turn away from hierarchical-custodial forms of organization. The continual correction of false attitudes and the conflicts resulting from that constitutes the therapeutically-rehabilitatively-effective factor within the therapeutic community.

However, an effective therapeutic community does not arise merely due to the introduction of some new measures (for example, establishment of a patient council, general meetings, group inspections) and the renaming of the station as such. To achieve that, we need, as prerequisite for the alteration of the in-house climate in the hospital, a change in attitude, a complete rethinking process on the part of the institution staff members. This rethinking process involves ethical categories to which increased attention should be devoted.

Kabanov (1973) in this connection fell back upon medical deontology, the theory of the behavioral principles of medical personnel with the objective of achieving greater therapeutic-rehabilitative effectiveness and reducing any possible disturbing factors in medical work. It is a component of medical ethics and, in Kabanov's opinion, which we fully agree with, it has so far been given too little attention in psychotherapy and psychology in favor of medical tactics or, in other words, in favor of professional behavior.

Rehabilitation includes the appeal to the patient's personality, preserving the principles of partnership, and it is aimed at unfolding the patient's

personality. Extraordinary significance must be assigned above all to the attitude of medical personnel to the psychiatric patient in terms of values held by such personnel because the heaviest communications volume is found in the therapeutic collective between the nurses and the patients. If the therapeutic community is to become effective, then, along with the reduction of hierarchical-authoritarian structures, there must be a change in attitude on the part of clinic staff members toward partnership communication and cooperation. This process is very long-drawn-out. It is connected with a role change from the supervising attendants with the keys to the actively therapeutically working cooperative partner. "Only a gingerly evolution can convert the psychiatric hospital, with the traditional structure, into a therapy community hospital. Authoritarian attendant personalities will have to be influenced more strongly and for a longer time before they can adjust to the principle of the therapeutic community." Fear of loss of authority plays an important role in all nurses and attendants (Flegel, 1966 and 1968).

The important thing is to develop a group norm and the connected norm pressure within the therapeutic community so that as many staff members as possible may find and tread the narrow path between the laissez-faire principle and relapse into the ego-weakening hierarchical-authoritarian structures. This narrow path embodies the social-psychiatry intention and is the third way which can be called the democratic guidance style.

In order that the therapeutic community will remain not just a dreamy-romantic vision, therapy personnel must be equipped with a corresponding psychological behavior repertoire. The latter however can be fully effective only if it is not used as a technique but rather if it contains congruent fundamental attitudes.

Starting with the current development level of medical personnel, it is necessary to develop the clinic staff members--especially the nurses and the male attendants--into socially competent identification models from whom the patients could adopt socially adjusted behavior in a learning process. To materialize this model function it is necessary to implement three fundamental attitudes which were introduced by Rogers (1957) and which are "absolutely positive attention," "empathy-based understanding," and "genuineness," meaning identity of what is felt and what is said by the therapist.

Moreover, quite a few rehabilitative situations (for example, discussion on the necessity of participation in the group) also demand control and consistency. For the latter, one could adopt a concept borrowed from pedagogic psychology: therapeutic-rehabilitative (pedagogic) goal orientation and persistance or rigidity connected with specific activities (Schroeder, 1976).

The implementation of these principles represents the previously mentioned rehabilitatively effective sociotherapeutic "basic behavior." A nice example of the implementation of this form of behavior in everyday routine

at the sickbed, in other words, certainly also in the somato-therapeutic area, was published by Hauschild and Mann (1976) through their concept of partnership-based conflict resolution and problem solution in the therapeutic community. This is a contribution which should be picked up not only by university graduates but also above all by nurses and male attendants because, in addition to guidance for practical work, impulses are also transmitted for positive attitude changes toward the patients.

The therapeutically and rehabilitatively positively working characteristics have yet to be passed on to the majority of clinic staff members. Possibilities must be found to elevate the interpersonal relationships in the hospital to a higher level through the basic and advanced training of nurses and male attendants. Only through the acquisition of the corresponding psychological armament is it possible for such personnel to become socio-therapeutically and psychotherapeutically effective team members. The initial positive approaches in that direction can be found in the job profile for specialized attendants (nurses) in psychiatry which has just been developed.

But before any further development is possible, we need an analysis of what we have achieved so far. Because of the taboos in doctor-patient relationships and the shadow they cast, we still have hardly any investigations and results in this respect on attendant-patient relationships either.

Investigations in our clinic (Feldes, 1974) showed that the attitude to the patient in social-psychiatric stations is at the boundary line between ambivalent and positive. In the specialized psychiatric hospital, it is ambivalent and tends to be rejecting. Here again there are big differences between the receiving stations (ambivalent attitude) and the closed chronic stations (attitude ranging from rejecting to ambivalent). Investigations in conference groups on valence (sympathy, closeness, understanding) and power (dominance, influence) on the part of the therapists yielded results which point merely to neutral benevolence and to an inclination toward domineering and commanding behavior in dealing with the patients.

These investigations showed that there are still considerable authoritarian-hierarchical residues which burden the therapeutic-rehabilitative in-house atmosphere in psychiatric facilities. The above-indicated discrepancy between social-psychiatry-oriented stations and the traditional psychiatric installations was once again confirmed by Feldes (1976) with respect to authoritarian-hierarchical behavior. The more positive attitude on the part of social-psychiatric care personnel, as documented here, he traced back to many long years of basic and advanced training efforts by the particular clinic management and he called for more intensive work with nursing personnel for the case of the traditional facilities.

In agreement with Benedetti (1973), Kabanov (1973), Schulte (1963), and other authors we are of the opinion that psychiatry is an indispensable component of rehabilitation. Rehabilitation is the personality development

of the patient which takes place within the framework of social learning. The patient must actively accomplish the necessary attitude and behavior corrections in a reciprocal relationship with the therapist.

So far, we have mostly covered the therapists and the behavior they must display in this study. It is just as necessary to go into the requirement for the patients in the rehabilitation process.

The previously mentioned traditional expectations regarding the role of the patient, with which the patients most identify according to tradition, constitute an essential partial cause of the passive consumption of therapy. The partnership-based reciprocal relationships between the patient and the therapist can become fully effective if the psychic patient changes from a passive object of therapeutic endeavor to an actively acting subject. On the side of the patients, there is just as great a makeup requirement when it comes to the change in attitude toward the therapeutic process as there is on the side the therapist. In the context of social learning, the patient should not only imitate but should adopt in an actively selecting and identifying manner. Here, the norms and behavior models presented to him must not be too high; they must be adjusted to his possibilities. We cannot have a situation where the therapist or his institution picks the patient out for a certain method; instead, the methods must be picked out for the patient. That means that the methods exist for the patient and, not the other way around, in other words, the patient does not exist for the method.

In our opinion, that applies not only to the rehabilitation of psychotic patients but also neurotic patients. In practice it is particularly the psychotherapeutic special divisions for neurosis therapy which still quite frequently deviate from this necessity (in unofficial slang, there are subdues whisperings about aptitude tests for the patients with respect to "special therapy.") In 1970, Leuner presented the need for adopting rehabilitative principles from psychiatry for neurosis therapy in an interesting contribution.

The therapist must avoid the desire to fashion his self-image or ideal image in the patient. This would lead, via the detour of well-meaning and overwhelming rehabilitation, to the manipulation of the patient; it would place the therapist, as a partner, above the patient, as a partner, and it would represent a relapse into authoritarian behavior. Instead of striving for excessively high rehabilitation results which demand too much, patient and therapist should adjust to the attainable degree which in the individual case can for example also be below the premorbid occupational level. That can be a measure of relief for the "patient who is restricted in terms of communication and emotion" because "higher-level occupations contain a higher level of conflict dynamics" (Haefner and von Zerssen, 1964).

During the transition from passive object to active subject in the therapeutic-rehabilitative process, the patient must assume responsibility not only for himself but also in matters concerning other fellow patients as part of the community. He must become competent for himself and for others. He must act in an actively emancipatory fashion, that is to say, on the one hand, with help from the clinic, he must extricate himself from the lowest level of the hospital hierarchy and, on the other hand, he must actively participate in the interests and the development of the group. According to Mann (1976), the emancipation of the psychiatric patient is "the ability to achieve liberating self-expression in the sense of becoming aware of the group as a whole and in the sense of the advancement of one's own interests, also considering of course the interests of others. This means that emancipation also includes a certain measure of sensitivity not only regarding one's own interests but also those of others."

The emancipation of the psychic patient from passive object to active collaborator in the therapeutic community is the materialization of social responsibility under the conditions of the psychiatric ward. The patient preserves for himself or obtains for himself in this fashion a basic social right also within the hospital.

FOOTNOTE

1. Parsons' investigations on the patient role were conducted under the conditions of bourgeois society. The starting conditions and the persistence of authoritarian structures in our health system are essential causes for the continued existence of these role characteristics. For the younger generation of course we can observe a welcome role change in doctor-patient relations (Winter, 1973).

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Clinical, Personality-Oriented Therapy

East Berlin PSYCHIATRIE, NEUROLOGIE UND MEDIZINISCHE PSYCHOLOGIE in German Vol 30 No 11, Nov 78 pp 641-647

[Article by Viktor Markovich Volovik and Viktor Davidovich Vid, Bekhterev Institute, Leningrad: "'Psychological Defense' as Compensation Mechanism and Its Significance for the Psychotherapy of Schizophrenia." According to a footnote, this article is taken from a lecture to the All-Union Congress of Psychiatrists and Psychologists held in Leningrad in 1976; the footnote also refers to a publication entitled "Psychological Problems of Psychohygiene, Psychoprophylaxis, and Medical Deontology," Leningrad, 1976. Persons seeking copies of the article are directed to Prof Weise, director, Karl Marx University Psychiatric Clinic, Leipzig]

[Text] Summary. The concept of psychological compensation is explained here as an essential aspect of the patient's adaptability; without consideration of that compensation,

it is impossible to draft a theory of personality-centered therapy. On the basis of the theory of relationships by V. N. Myasishchev, the concept of F. V. Bassin, and the Rozhnovs on "psychological defense," the article takes up several special features of psychological compensation in schizophrenia. The first-ranking significance of the clinical method in the determination of such processes and the danger from the errors inherent in "comprehending psychopathology" and "psychodynamic psychiatry" in underscored.

Some earlier publications already concentrated on the foundations of psychotherapy and the closely related questions of the personality theory in connection with the treatment of theoretical problems of medical psychology. The link between these theoretical fields is a central problem of medicine, that is, the individual's adaptation activity, including the question as to the level and the manner of compensation. In addition to physiological compensation processes, which have been investigated relatively thoroughly and which have been thought out carefully in conceptual terms, the investigation of psychological compensation mechanisms, which are included in the most complicated and very little researched field of knowledge on the individual, assumes particular significance in connection with the theory and practice of psychotherapy and rehabilitation. Besides one can observe with certainty that, without a consistent presentation of these complicated questions from the positions of Marxist methodology, it is impossible to formulate a compact theory on personality-oriented group psychotherapy.

On the level of the overall personality one can term the process of psychological compensation in the disturbance of its balance as "psychological defense" corresponding to "physiological defense" (biological adaptation reaction of the organism on the biological level). The circumstance that the origin of this term is connected with the concepts of Freudianism, which are alien to us, should not be viewed as a disturbing factor but does call for an exact definition of the new contents. This kind of approach is particularly necessary under the conditions of the aggravation of the ideological struggle whose arena in our days also includes psychology.

In psychoanalytic literature, in which it was formulated originally, use was made of the term "psychological defense" to designate a complex of depth-psychology processes of a predominantly neurotic character which are oriented toward the elimination or reduction of the mostly intrapsychic conflict between the undifferentiated, archaic instinct drives of man and his mature, conscious social attitudes which are connected with the standard requirements of society. The one-sidedness of the approach and the mechanisms of psychoanalytic interpretation of "psychological defense," which brought about its unproductivity and theoretical untenability, were subjected to justified and many-sided critique and recently were admitted even among the supporters of "depth psychology." Many of those advocates, such as, for example, Arieti, Benedetti, and Kind, dissociated themselves

from acceptance of the theory of the "libido" and investigated psychological defense processes which are conditioned by a conflict in the area of conscious attitudes. On the other hand, looking at Soviet literature, we can detect a tendency toward the critical rethinking of the principal concepts of psychodynamics from the positions of materialist psychology, considering the positive content of the facts and clinical objects backing them up. Among others we might mention here above all the works by P. V. Bassin but also those of Bassin, Rozhnov and Rozhnova, according to whose opinion the concept of "psychological defense" reflects an important aspect of psychic activity which represents a normal mechanism of adaptation to difficult life situations which is at work every day. From that viewpoint, "psychological defense" is construed as a process aimed at the reduction of the emotional tensions accompanying conflicts and the prevention of a disorganization of behavior in the confrontation of conscious attitudes with conscious or unconscious attitudes contradicting them.

Within the context of this concept, Bassin, Rozhnova and Rozhnov designed some mechanisms of "psychological defense," to wit: neutralization of emotional tension during the switch of interests of the personality to another, broader and more important activity; the switch from an attitude that cannot be implemented to another one which can be implemented; the change in relationships and the reduction in the emotional valence of phenomena. These mechanisms have for a long time been in the pathogenically based psychotherapy of neuroses, formulated by V. N. Myasishchev on the basis of the theory of relationships. Reference was also made to the existence of other, even more complicated forms of personality adaptation which call for a further, even more in-depth investigation.

The investigation of mechanisms of psychological compensation in the psychiatric clinic is important because the determination of ineffective forms of "psychological defense" serves as the point of departure for the implementation of a personality-oriented psychotherapy and is the basic requirement for the effective attainment of its main goal, that is, getting the personality to function to the fullest extent.

What we have said so far is justified not only by the therapy of neuroses, where a psychotherapy of this kind has a causal character. In diseases of a somatogenic character (as, by the way, also in the clinic of some somatic ailments), the development of adequate forms of "psychological defense" is one of the means for attaining effective adaptation. In schizophrenia--in whose phenomena and course personality-specific and situational factors are particularly significant especially in the less advanced forms--the reinforcement and the rational regrouping of psychological defense mechanisms play an essential role and personality--oriented (predominantly group) psychotherapy represents the foundation of restorative therapy in a series of cases.

Both dissimulation of morbid experiences and their rationalization--which promote the development of adequate behavior--should also be considered as being included in the term "psychological defense"; we must furthermore

mention pathological fixation on the illness which not infrequently can be observed at the end of a psychosis. Such a soberly and traditionally thinking psychiatrist as Weitbrecht in his excellent analysis of extreme and speculative ideas--which has penetrated the clinic of schizophrenia--inclines toward the recognition of the defensive character also of some other peculiarities of patients, such as, for example, the "forgetting" of psychotic experiences whose discussion leads to a renewed flareup of the psychosis. D. Ye. Melekhov also reports on cases of "decapsulation" of delusion in patients who were in the period of remission, after intensive questioning pertaining to earlier morbid experiences by the advisory commission of doctors. In recent times, Kovalev similarly considered some forms of psychopath-like behavior on the part of schizophrenia patients.

The inadequate evaluation of personality factors, inherent in the one-sided somatobiological approach to schizophrenia, is just as far removed from clinical reality as the absolutization of the role of the psychic (or, more specifically, the psychogenic) by the representatives of the psychodynamic school who are inclined to consider all schizophrenia as a system of reactive psychological defense processes arising on the foundation of a primary weakness of the "ego." A dualist separation of the symptoms of schizophrenia into primary, "physiogenic," and secondary, personality-conditioned ones, can hardly be accepted because, in each of their phenomena, we have simultaneously a cerebral syndrome and the sequels of their processing by the personality, as result of which the psychogenic and somatogenic factors are woven together into a uniform process of syndrome genesis. The incompleteness of such a subdivision had to be admitted even by Bleuler himself already in 1930. Nevertheless, one must distinguish between the illness as such and the phenomena of the "psychic life of the illness," such as it was explained by E. Bleuler and such as we perceive them in the establishment of natural interpersonal relations with the patients. The schizophrenic process, which distorts the reciprocal relationships between the patient and reality, does not eliminate socially determined relationships whose one-sided evaluation, from psychopathological positions, often proves to be false. The adequacy of "psychological defense," as well as the ability to put it together, must naturally be viewed as a function of the degree of preservation of the patient's integrative capabilities and intellectual possibilities.

The less the personality has been disorganized by the psychotic process, the more essential is its share in forming the clinical picture. During the early stage of schizophrenia, personality changes--including those that represent defective forms of "psychological defense"--can determine the condition and peculiarities of the patient's social adaptation. In addition to the personality type, the individual experience, and the specific real-life situation, one must keep in mind that mental illness puts the patient in a special situation within society by virtue of the very fact that it has been established as such. Objective restrictions of social activity, spelled out by social institutions, or undertaken as a result of an actual or presumed change in the behavior of social reference groups, will play an essential role here.

The traditional concepts about psychic illnesses in society and the anticipated consequences of going to see a psychiatrist are of no less significance. In this way, "psychological defense" can be oriented not only toward situations connected with the illness but also toward conflicts which are in no direct relationship to it.

This determines the structure of relations between psychological compensation and the internal clinical picture to which increasing attention has been devoted in recent years. In this connection we would like to alert the reader to one inadequacy in many interesting studies devoted to the internal clinical picture as a central psychological structure of the sick individual's personality. This inadequacy consists in the fact that the internal picture of the illness is taken out of the social context and that one discusses it outside the relationships that are essential to the personality. One of the important conclusions which we arrived at, as we investigated the illness awareness of patients with slightly advancing schizophrenia, consists in the sociocultural determinateness of essential aspects of the patient's ideas as to his own illness (when illness phenomena are noticed, the patient evaluates the latter on the basis of socially acceptable standards) and the indirectness of relations to the illness due to situational-psychological moments. This is why, for example, anosognosia for the ailment cannot in each case be considered only from psychopathological positions as the absence of critique. In the beginning, the failure to recognize the illness can also be found in the patient's next of kin and can have a defensive character not only in the patient but also in the family members.

The group psychotherapy situation creates the best possibilities for the investigation of the variations of "psychological defense" because it makes it possible to observe their phenomena under the conditions of interpersonal relations, that is to say, in the process of objective activity. The principle of activity, which was formulated by Rubinstein, Vygotskiy, and Leontiyev and which has attained fundamental significance in Soviet psychology, here attains a concrete, visible expression. Failed forms of defense, which lead to a relative adaptation on a lower level that does not correspond to the personality's actual possibilities assume particular significance here. In the analysis of psychotherapeutic material, we can constantly track three forms of changes in relationships which correspond to this level:

1. Defensive "agnosia" of a conflict problem complex not perceived as such. Here we include a large number of variations of defense retouching of an objective reality which has traumatized the psyche, starting with minor distortions of the internal clinical pictures and ending with pronounced "skotomen" [disorientation] in the perception and evaluation of objective reality. The establishment of this fact of course cannot serve as foundation for expansion into the field of psychopathology and the acceptance of principles of existentialist psychiatry in the interpretation of the mechanisms involved in the development of illusions.

2. Changes in the scale of contradictions, underlying the conflict experiences, and their place in the system of relations important to the personality.

3. "Paralysis" of motivation, whereby the patient more or less adequately perceives the problem, the inability to solve it, or the fear of failure but destroys the drives for the necessary actions, whereby here, as in the first two cases, we are by far not dealing with the application methods of "comprehending psychopatholoty" and the attempt at a psychologically understandable interpretation of conditions of apathy and abulia. We believe that the purely psychological interpretation of other systems of schizophrenia --such as, for example, autism (whereby autistic behavior in certain cases can have the character of defense), are just as unfounded. Tendencies of such a kind are alien to clinical thinking. But if we avoid the temptation of subjecting ourselves to the patient's dangerous self-deception, which Mayer-Gross warned us against, in talking about the introduction of psychopathological investigation as a method, we must not allow the other extreme either, that is to say, we must not file all psychological findings and conditions under the category of psychopathological phenomena based on a somatogenic foundation.

The importance of considering the above-mentioned mechanisms is not only tied in with the fact that many of them were formed on the unconscious level, which makes it more difficult to illustrate them (excessive elevation of the demand level which the person does not become aware of, excessive increase in the emotion valence of conflicts experienced, "exchange" of sympathy and antipathy objects, etc.); this is also connected with the idea that an artificial balance, which is thus created from time to time, blocks the formation of healthy adaptation mechanisms and the possible transition to a higher level of personality functioning. The rejection of such apparent, unstable advantages of nonadaptive defense and the transition to their more productive forms initially are painful and demand an active rebuilding of essential personality relationships by the patient--something which usually produces resistance. The recognition of his nature and his essence by the patient here is a necessary stage leading toward the attainment of the main goals of psychotherapy. In such an interpretation, overcoming the patient's resistance, in contrast to the half-mystical action of psychoanalytic procedure, assumes a visible character which is accessible to qualitative and quantitative analysis and which represents the process of moving the patient on into a new form of behavior adaptation.

We can anticipate the possibility of serious objection to some of the theses which we submitted. The questions taken up are complicated but belong to the least investigated fields of the psychology of relationships. Nevertheless, these problems face us in the practice of rehabilitation. Their exploration and solution, from the theoretical-methodological positions of Soviet science, is an urgent necessity. The key position of these questions in the theory and practice of psychotherapy makes their discussion even more timely. Although we are far removed from a psychogenic concept of

schizophrenia and although we view the latter as a chronic system illness of the brain, we nevertheless endeavor to show that, in psychotherapy, in the case of patients with a less progressive schizophrenia, under certain conditions, we can face the same tasks as in the therapy of neuroses--with the essential difference that the solution of these problems does not touch the procedural foundations of the illness.

The theses formulated here were justified by the thorough analysis of the process of group psychotherapy in a group of patients that was defined in clincial terms and that was followed up catamnestically. We hope that this circumstance helped us in avoiding elements of the kind of subjectivism which is not infrequently present in investigations of this kind.

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Multidimensional Diagnostic Approach Necessary

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[Article by Michael Kreyssig, MD, Karl Marx University Psychiatric Clinic, Leipzig (Prof K. Weise, MD, director): "Sociodynamic Aspects in the Framework of Multidimensional Diagnosis of Mental Illness"]

[Text] Summary. After a critical dispute with the traditional diagnosis of psychic ailments oriented rather one-sidedly by the nosological model and after rejecting the exclusivity claim of either somatically or psychosocially oriented approaches of etiopathogenesis, the author describes the synthesis of these approaches in the form of the multidimensional diagnosis, guided by the universal-genetic-multifactorial concept, with the psychodynamic, sociodynamic, somatic, syndromatological, and nosological dimension as the foundation of therapy and rehabilitation which corresponds to the present-day level of knowledge in our specialized field. The sociodynamic level--which was taken out of context for the purpose of this study--with its diagnostic and therapeutic-rehabilitative consequences for social-psychiatry-oriented psychotherapy is also discussed here.

At the very latest since Griesinger, it was considered valid in psychiatry that mental illnesses are ailments of the brain. This hypothesis--because that is what it is (Weitbrecht, 1959; Winkler, 1967; Janzarik, 1969)--constitutes the basis for traditional diagnosis in psychiatry. Behind this

hypothesis we have the dogma of somatosis which led to a methodological narrowing of research in our specialized field (Janzarik, 1969).

Kraepelin (1883) is considered the outstanding representative of the nosological research direction which, on the basis of an exclusively somatic-natural-science approach to illness, during the second half of the nineteenth century postulated the "nosological unit." The foundation of the latter is a uniform approach which is expressed in the triad "same cause, same phenomenon, same course."

Although he was caught up in the natural-science thinking pattern of his time, Griesinger (1861) took the first steps toward a not exclusively somatic approach in that he included psychic causes among the "sources of insanity," by which he meant above all the wrong educational methods used by the parents, such as, unfavorable and twisted influence on the child's perceptions and will, as well as tough, grief-inflicting and humiliating behavior that inhibits the development of the personality. Even in his later years, Kraepelin (1920) doubted the exclusivity of the hypothesis of psychic illnesses being conditioned by somatic factors. With resignation he observed that clinical-psychiatric research has wound up in a dead-end street because "past procedures were used up in the effort to outline forms of disease through the inclusion of causes, symptoms, course, and outcome"; he tried to understand the illness phenomena in the area of the patient's personality. E. Bleuler (1911) likewise considered that a physical illness process was not the indispensable requirement for schizophrenia and that the symptoms could also be psychically determined. He accepted the compromise that the primary symptoms, created by him, are an expression of somatosis and that the secondary symptoms are the consequence of the failure on the part of the patient to adjust to the primary symptoms.

The derivation of a direct causal relationship from the descriptive symptomatological finding (the syndrome) to the somatopathological process so far has not been possible. It was especially the filigree-like subdivision and arrangement of psychopathological syndroms into numerous subgroups (Leonhard, 1957), reflecting a real aspect of psychic illness, that were undertaken from this viewpoint. The development of syndromatology on the one hand is necessary in tackling certain problems (for example, systematicity and syndrom-oriented therapy). But on the other hand one must question whether it is the only way leading to etiopathogenesis for methodological reasons. Beyond that, past efforts to gain access to etiopathogenesis from the syndrome were unsuccessful although that cannot justify the assumption that partial somatic factors should be denied.

The merit of the traditional diagnostic approach during the last century consisted in the fact that psychic aliments were extricated from their mystification and that psychic patients were helped in getting medical treatment by giving them more equal status as compared to somatic patients.

Contrary to Janzarik's opinion (1969), the unified [unity] psychosis is not the counterpart of the nosographic approach; rather, it is above all the

concept of the exclusive psychogenesis and sociogenesis of schizophrenia (Arieti, 1959) which is so widespread in Anglo-American circles.

Both the exclusively gnosographically-oriented and exclusively psychosocially-oriented schools permit only partial statements and, because of the above-mentioned exclusivity in the sense of the "either-or concept" (Kind, 1965), prevent the synthesis of etiopathogenically significant dimensions.

The traditional diagnostic approach, which for many reasons is still widespread in our country (a partial cause of this is to be found in the traditional concept of sickness and the danger of training medical students to become somaticists, or organ therapists, a danger which can be noted at least in the area we are looking at here) and which undoubtedly can also look back to the above-mentioned achievements, is expressed in the clinic mostly in the somatodiagnostic and therapeutic procedure. The natural-science aspect of the illness model is necessary, on the one hand, but, on the other hand, due to the narrowing of the field of vision, due to exclusivity does not do justice to present-day requirements arising from the complex therapy and rehabilitation of psychic patients. It should not therefore be abolished but it must be supplemented. It is rather strange to note that patient records still concentrate merely on a descriptive-psychopathological finding, not to mention epicritical reports. This finding will, in spite of all exactitude and efforts, only meet the requirements of a syndrome diagnosis. But from that one cannot draw any conclusions as to the causes, as to the underlying illness process (Weitbrecht, 1959, and Weise, 1971, 1974). The syndrome is nonspecific with respect to the cause of the illness and, analogously, also with respect to the therapy. Other than syndrome-oriented therapy, whose tremendous practical significance is beyond question, there are not further therapeutic conclusions deriving from syndrome diagnosis. The dilemma of traditional diagnosis consists in the fact that essential dimensions which determine the development of the illness are neglected. But that means that it is not an adequate foundation for the planning and implementation of therapy and rehabilitation (Weise, 1971).

There are several possibilities of overcoming the kind of diagnosis which is conditioned by assumptions and which is oriented rather one-sidedly by the nosological or psychosocial model.

The most radical possibility consists in the negation of the diagnosis of psychic illnesses. In the opinion of Szasz (1960), diagnostic concepts only serve for the compensation of scientific vacuums anyway. Kisker (1967) stated that the traditional concept structure of descriptive psychiatry "is a scientifically discarded expression of that same fear and helplessness which also fashion the vulgar relationship of society toward insanity." K. Doerner tries to cure psychoses by means of communication and the closeness of sympathetic human beings, skirting diagnosis (personal communication).

The possibility which we consider most useful is the concept of the multidimensional diagnosis of psychiatric ailments. It represents the synthesis of the previously mentioned counterparts of the exclusively nosographic

and exclusively psychosociogenic approach and is thus a genuine alternative to these diagnostic concepts.

E. Kretschmer (1927) was a pioneer in this field. Through his sensitive relationship delusion he introduced a diagnostic concept which from the very beginning was designed in multidimensional terms and which was to be used for a psychopathological syndrome of psychotic gravity. Here is what he said verbatim: "Character, environment, and experience are the triad which--reciprocally cumulative--generates the sensitive relationship delusion." In the somatic dimension he speaks of considerable stress, schizoid and circular disposition, and climacteric emotional changes. He thus introduced psychodynamic, sociodynamic, somatic and syndromatological diagnosis. These diagnostic levels are correlated in Kretschmer (1957) with the therapeutic concept which he advocates. Kretschmer thus by no means denied the somatic aspect; instead, using the dialectical law of the negation of negation, he denied the one-sided and inhibiting character of this aspect and integrated its positive qualities into a higher level.

According to the Tuebingen school, looking at the German-speaking area, to give just a few examples, multidimensional diagnosis was taken over and developed further especially in Vienna (Hoff and Arnold, 1958, 1963, and Gastager, 1965) and, for more than 10 years, also in Leipzig (Weise, 1971).

The application of multidimensional diagnosis logically contains the recognition of the fact that psychopathological syndromes are conditioned in a multifactorial manner.

Famous nerosis therapists also base therapy on a multidimensional diagnosis. This is to be found explicitly in Kohler (1968) who, in addition to the psychic and social conditioning of neuroses, also expressly recognizes a somatic reaction readiness. Klumbies (1971) likewise considers the three diagnostic levels. Instead of somatic reaction readiness, he mentions a "locus majoris irritabilitatis" [a place of greater irritability], something which is the same in terms of content. Hoeck and Koenig (1976) circumvent the somatic level inasmuch as they separate psychosomatic illnesses from neuroses. But by assuming that constitutional factors, which are not sufficiently supported considering the present level of knowledge, promote the appearance of a neurotic disorder, these authors are flirting with the multidimensional concept.

Considering this statement and the definition and pathogenesis of neurosis, especially regarding the primary psychic disorders, where inadequate norms and concepts are acquired in early childhood on the basis of a distorting educational atmosphere (Hoeck and Koenig, 1976) and to a lesser degree due to radical childhood traumas (Kind had the same thing to say in 1965 regarding schizophrenia), we inevitably come to the question as to where, outside the syndrome area, we find the difference between neuroses and non-symptomatic psychoses (endogenous, respectively, experience-reacting), because, considering the present level of knowledge, a purely somatic cause

of the above-mentioned psychosis group is unknown and the quantitative share of genetic factors is not securely determined either. This question is further accentuated by Rennert (1965) in that he recognizes transitions between neuroses and psychoses on the syndrome level.

Along with Conrad (1959) and Janzarik (1969) and criticizing the 3[illegible] disease units listed by Leonhard as being "based on heredity and biology and as being prognostically determined," Rennert (1964) came out with the thesis of the uniform psychosis or the universal genesis of endogenous psychoses. By that he means that the syndromes are multifactorially arising responses by the personality to a uniform anonymous disease penetration. Universal genesis is sustained, in terms of definition, by multifactorial conditioning and thus agrees with the concept of multidimensional diagnosis. By reducing the assumption as to universal genesis and the multidimensional concept to its rational nucleus, it seems legitimate to use both concepts synonymously. Due to the neglect of multifactorial conditioning, Petrilovich (1970) saw a presumed contradiction between the concept of uniform psychosis and the multifactorial approach. He downgraded the significance of uniform psychosis to an uncertain version of the view as to the firmly structured illness units.

The assumption as to the universal-genetic multifactorial conditioning of psychopathological syndromes broadens the diagnostic field of vision and, through a separate recording of all etiopathogenically significant areas, makes room for comprehensive differential-diagnostic efforts. In this way, diagnosis becomes the analysis of the pathogenesis of psychopathological syndromes. Each of the previously mentioned diagnostic dimensions provides statements which are the foundation of therapeutic-rehabilitative procedure. In the illustration of these levels, we need a formal separation of the interrelationships found here for methodical, rational, and typological reasons.

This phenomenon of multidimensional diagnosis caused Volovick (1975)--who with his functional diagnosis likewise covered significant etiopathogenic areas in a multidimensional manner--to express criticism by noting that the psychic aspect is isolated from the somatic aspect and that the psychopathological aspect is separated from the pathogenic mechanisms. The essence of multidimensional diagnosis however consists in the fact that, after analysis in the form of the multidimensional breakdown, the synthesis is accomplished within the framework of complex therapy and rehabilitation covering all levels.

In the following part of this study we will separately take up the sociodynamic level with its two components, which are sociodiagnostics and sociotherapy. In so doing we do not want to say that this level has priority over the others or that it can be dealt with in an isolated manner in the course of clinical practice.

The concept of sociodynamic diagnosis comes from Gastager (1963). The diagnostic level thus defined enables us to record pathogenically relevant

social constellations with the resultant role expectations and interpersonal conflicts from the premorbid phase. Moreover, one can record social changes which likewise go hand in hand with the illness and which take effect in a secondary pathogenic and rehabilitation-opposing manner (for example, abnormality barrier, von Baeyer, 1951). In other words, we are dealing here with the recognition of primarily and secondarily effective social illness causes.

If we have the corresponding diagnostic intention and intensity, one can regularly prove that abnormal personality-psychology characteristics, such as they occur in sui ide, addiction, neuroses, and also in the phase prior to psychotic illnesses, are correlated with a disturbed socialization process.

Similar to the above-mentioned view held by Hoeck regarding the pathogenesis of primary neurotic development, Winkler (1967)--who was mostly concerned with the sociogenesis of schizophrenia, thought "that the manifestation of schizophrenia is preceded by abnormal social processes"; and, under the aspect of sociodynamics, he subdivided schizophrenia, as a social process, into several stages. The first one of these begins in childhood, whereby, via sociogenic development, there arises a latent disposition toward schizophrenia whose psychological characteristics, among other things, are ego weakness, adaptation disturbance, and contact restriction. Among other authors, who pointed up the disturbed social constellation of the person, who later on develops schizophrenia, during childhood we might mention Lidz and associates (1959), Kisker and Stroetzel (1961), Kind (1965), Petermann and Schroeder (1971).

That tensely burdensome social situations are also significant for the pathogenesis of so-called endogenous affect psychoses emerges from the work of Tellenbach. On the basis of differentiated clinical observations, he was able to establish that certain personality types ("typologically depressives") under special social stress ("includence and remanence situation") react with a depressive syndrome (1961). For the type of the predominantly manically cyclothymal individual--who supposedly constitutes "a certain modification" of the typologically depressive--there is likewise supposed to be the danger of manic decompensation (1965) under a stressfully developed social situation ("pressure situation").

For sociodiagnostic requirements and the resultant therapeutic-rehabilitative necessities, it is immaterial whether the nonsymptomatic psychoses involve a biological process with merely secondary psychosocial changes or a primary psychosocial process, even if the above-mentioned viewpoints seem to point more toward the latter.

In the diagnostic situation, the therapist is first confronted with the psychopathological striking features of the patient. The psychopathological phenomena can be interpreted almost throughout in a social manner (Winkler, 1967), although not directly but through the detour of their psychodynamic

processing. The separation of incompatible consciousness contents and their placement outside--which thus lose their ego quality (ego anachoresis, according to Winkler, 1957) and the wiping out of guilt due to ego mythification (Winkler and Wieser, 1959)--point to a dissociation from personal endeavors and needs which do not agree with the patient's life design. The self-value elevation due to the omnipotence-radiating delusion idea or the ego-disturbance in the sense of being guided and steered are an expressin of premorbid self-value disorder. The feeling of being observed and controlled is correlated with the missing or inadequate possibility of developing a personal intimate sphere.

Denial of personal wishes and endeavors, abnormal life design, impaired development of a healthy self-value experience or suppressed development of the intimate sphere are mostly the direct consequence of unfavorable social developmental conditions. Moreover, the psychopathological phenomena and their interpretation often supply sufficiently reliable references to the delimited position of the group of principal socialization sources as against the social environment, because of which the promoting influence from other social structures (for example, school, recreation group) is considerably impaired (Weise, 1971).

In addition to difficult social patient-history surveys (the routine exploration pattern used by our clinic encompasses about 100 key words which are significant in terms of social patient history) demands the diagnostic selection of the sociodynamic level [and] the use of the psychologist's diagnostic inventory. According to Feldes (1971), the social position of the psychic patient is of interest especially in three areas. They are the therapeutic group in the hospital, the patient's family, and other social groups with which the patient has relations (occupational and recreational group). Quantitative procedures for the measurement of the attitude toward the psychic patient or the formerly psychic patient were developed at our facility by Feldes (1971, 1974). They tell us something about the degree of readiness to communicate with psychic patients. Differences between self-estimation and outside estimation, which can be measured by means of polarity profiles, supply hints as to discrepancies between the self-image and the outside image, about the patient's ability to come with a realistic self-estimate and to achieve social integration, about his contribution to the attainment of the group objective and about the group's homogeneity. The family Rorschach provides information on interaction and dominance within the group examined. Methods to measure social behavior likewise supply information for the purpose of discovering sociodynamic events.

Multidimensional diagnostics, by means of which the static phenomenology of classical psychopathology (Windler, 1957) could be overcome, serves the requirements of therapy with all of its etiopathogenically significant sectors.

The sociodiagnostic level supplies the point of departure for sociotherapy which goes far beyond just occupational rehabilitation. Sociotherapy is to be carried out in an optimum manner within the framework of the therapeutic

community which is a foundation of social psychiatry. The therapeutic community is sustained by the partnership-based relationship between patients and clinic staff members. To achieve this form of behavior, we need an attitude change on the part of the members of the therapist team toward the patients. Within the framework of such a structure, the patient can correct inadequate social behavior through social reciprocal relationships with the therapeutic group and can replace it with adequate social behavior. Moreover, sociotherapeutic efforts must be aimed at the environment of the patient, primarily the family and the fellow workers on the job in order to reduce harmful social relationships there and to eliminate the attitudes of the reference persons which constitute the foundation for such relationships.

In the broadest sense, sociotherapy is psychotherapy (Benedetti, 1973). The social behavior of the therapists which is to be implemented here and which enables them to become identification models for social learning was described on the basis of the behavioral rules of Rogers (1957), Hauschild and Mann (1976), with the help of their concepts on partnership-based conflict and problem resolutions. They informed us not only about behavior that must necessarily be implemented but they also demand that corresponding personal basic attitudes must be developed.

Much has been said and written about social psychiatry. Where it is really to be implemented, we must--in addition to the corrections of the attitudes of staff members and organizational changes--get away from nosological thinking in favor of multidimensional diagnostics because this is the only way to meet all therapeutic requirements. The establishment and organization of new subdivisions, called social psychiatry or therapeutic community, will lose their effectiveness if the multidimensional approach is not developed simultaneously in diagnostic-therapeutic thinking because traditional diagnostics can only be the foundation for traditional therapy.

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LASER RADAR INSTALLED ON SATELLITE OBSERVATION DEVICE

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[Article by H. Domogalski, Chamber of Technology; GDR Academy of Sciences, Central Institute for Terrestrial Physics, Postdam: "Quasi-continuous Control of a Satellite Observation Device"]

[Abstract] A laser range finder developed at the Central Institute for Terrestrial Physics is being used to track and control satellites on orbits at a 1000-6000 km altitude with a measuring accuracy of 10^{-8} sec. Continuous tracking control was achieved in an angular rate range of 2×10^{-3} to 14×10^{-3} radians/sec. A circuit diagram and equations describing "phase intersect" control" and its practical application are given. Figures 5, references: 1 German.

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BRIEFS

ODRA-1305 COMPUTER INSTALLATION--An ODRA-1305 computer was sent to the Electronic Computer Computation Enterprise (ZETO) in Olsztyn from the "MERA-ELWRO" plants in Wroclaw on 13 July 1979. The ODRA-1305 computer installed in Olsztyn will replace the ODRA-1304 computer, which fulfilled important tasks during the initial phase of development of information science in Olsztyn (this was the first computer installed in Olsztyn Voivodship), and will be transferred to Lomza where a similar computer center is being established. [Excerpts] [Olsztyn GAZETA OLSZTYNSKA in Polish 19 Jul 79 p 3]

NEW COMPUTER USERS LISTED--New users of the following computers include: ODRA-1305 computer--Academy of Economics in Poznan, Electronic Computer Computation Enterprise in Krakow, "Merinotex" enterprise in Torun, "Agroma" enterprise in Szczypiorno near Kalisz, Construction Industry Electronic Computer Computation Engerprise (ETOB) in Lublin, ETOB in Zielona Gora, "Len" enterprise in Zyrardow, ETOB in Bielsko-Biala, Highway Engineering Main Computerized Information Center in Warsaw, Institute of Nuclear Physics in Novosibirsk (USSR), Airport Authority in Schonefeld (GDR), Lutrija enterprise in Zagreb (Yugoslavia), Workers' Publishing Cooperative "Prasa" in Warsaw, "Zygmunt" Steel works in Bytom, "Chemidex" enterprise in Tomaszow Mazowiecki, METEKON enterprise in Katowice, Industrial Telecommunications Institute (PIT) in Warsaw, Coal Industry Plants in Dabrowa Gornicza, Power Plant in Gliwice and OZO [expansion unknown] of the Polish State Railroads; ODRA-1325 computer--TESLA enterprise in Pardubice (Czechoslovakia), Nitrogen Plants in Kedzierzyn and UNITRA-RAWAR enterprise in Warsaw; R-32 computer--Mechanical Plants in Ursus, Motor Bus Factory in Sanok, ETOB in Krakow, KONSTAL enterprise in Chorzow, Predom-Projekt enterprise in Wroclaw, POLMO enterprise in Lublin, POLFA enterprise in Warsaw, ROMET enterprise in Poznan, Institute for Control Systems in Sosnowiec and the Warsaw Polytechnical School. [Text] [Warsaw INFORMATYKA in Polish No 6, Jun 79 p 40]

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